Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004440	A. BUILDING: _____ B. WING _____	C 07/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANDLER PLACE	**2879 S LIMA RD KENDALLVILLE, IN 46755**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00177931. Complaint IN00177931 -Unsubstantiated, due to lack of evidence. Survey Dates: July 20 & 21, 2015 Facility number: 004440 Provider number: N/A AIM number: N/A Census bed type: Residential: 38 Total: 38 Census payor type: Other: 38 Total: 38 Sample: 3 Chandler Place was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00177931.	R 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE